MENTALLY DISORDERED SEX OFFENDERS: EXTENDED COMMITMENTS

1. Summary of Chapter 991/79

Section 6316.2 of the Welfare and Institutions Code, as amended by Chapter 991/79, provides an extended commitment for committed mentally disordered sex offenders who suffer from a mental disorder, disease, or defect, and as a result of such disorder, disease, or defect are predisposed to the commission of sexual offenses to such a degree that they present a serious threat of substantial harm to the health and safety of others. In addition, it specified that a petition for extended commitment shall be filed 90 days before the expiration of original commitment and the court shall conduct a hearing on the petition no later than 30 days prior to time of release by the State Department of Mental Health. The trial shall be by jury unless waived by both the patient and the prosecuting attorney. The State shall bear all expenses of transportation, care and custody of the patient and all trial and related costs, and shall be represented by the Attorney General or the district attorney with the consent of the Attorney General. If the patient is an indigent, the State Public Defender shall be appointed.

Although Chapter 928/81 repealed Section 6316.2, it would provide that persons committed under this section would remain governed by this section until their commitments are terminated.

2. Eligible Claimants

Any county that has incurred increased costs as a result of this mandate is eligible to claim reimbursement of costs.

3. Types of Claims

A. Reimbursement Claims

A reimbursement claim is defined in GC Section 17522 as any claim filed with SCO by a county for reimbursement of costs incurred for which an appropriation is made for the purpose of paying the claim.

An actual claim for the 2007-08 fiscal year, may be filed by February 17, without a late penalty. Claims filed after the deadline will be reduced by a late penalty of 10%, not to exceed $10,000. However, initial reimbursement claims will be reduced by a late penalty of 10% with no limitation.

In order for a claim to be considered properly filed, it must include documentation to support the indirect cost rate if the indirect cost rate exceeds seven percent. A full discussion of the indirect cost methods available to counties may be found in the P's & G's. Documentation to support actual costs must be kept on hand by the claimant and made available to SCO upon request as explained in the P's & G's.

B. Estimated Claims

Pursuant to AB 8, Chapter 6, Statutes of 2008, the option to file estimated claims has been eliminated. Therefore, estimated claims filed on or after February 16, 2008, will not be accepted by SCO.

4. Reimbursement

Eligible claimants will be reimbursed for the costs related to extending commitment for mentally disordered sex offenders.

The costs of transportation, care and custody of the patient, trial costs, juror fees, and prosecuting district attorneys' costs if consent is given by the Attorney General for the district attorney to represent the State in proceedings under Section 6316.2 of the Welfare and Institutions Code is reimbursable.

5. Reimbursement Limitations

A. Trial Court Funding Program

Costs related to "court operations" as defined in Government Code Section 77003 are not reimbursable when the county opts into the Trail Court Funding Program pursuant to Section 77300. In light of Government Code Section 77003, the cost of trial and juror fees shall not be claimed if the county is participating in the Trial Court Funding Program. Pursuant to Section 77203, block grant disbursements to the county shall be in lieu of any reimbursement of state mandated local programs for trial courts during those fiscal years in which it is a participant of the program.

B. Support and Care of Persons

Counties that have an approved daily rate with the Department of Corrections must use the approved rate when computing reimbursable costs for care and custody of the prisoners. Since the prisoner is seldom in custody a full first day and last day of his or her hold, reimbursement can be claimed for the first day but not for the last day of the holding period.

Counties without an approved rate must compute a rate based on actual expenditures for the prior year as shown in the county budget. Allowable costs for computing the rate are; clothing, food, dining supplies, janitorial supplies, kitchen supplies, laundry, laundry supplies, bookings, and utilities. The average daily rate is computed by dividing the total allowable expenditures for the year by the average daily population. This quotient is then divided by 365 days. This rate may be brought up to an estimated current year rate by the percentage increase of current year operating expenses over past year operating expenses.

C. Offsetting Savings

Any offsetting savings or reimbursements the claimant received from any source, as a result to this mandate, must be deducted from the amount claimed.

6. Claim Forms

A. Form 2, Activity Cost Detail

This form is used to segregate the detail costs by claim component. A separate form 2 must be completed for each cost component being claimed. Costs reported on this form must be supported as follows:

1. Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed and specify the actual number of hours

devoted to each function, the productive hourly rate, and the related fringe benefits.

Source documents required to be maintained by the claimant may include, but are not limited to, employee time records that show the employee's actual time spent on the mandate.

2. Materials and Supplies

Only expenditures that can be identified as a direct cost of the mandate can be claimed. List cost of materials that have been consumed or expended specifically for the purpose of this mandate.

Source documents required to be maintained by the claimant may include, but are not limited to, invoices, receipts, purchase orders, and other documents evidencing the validity of the expenditures.

3. Contracted Services

Give the name(s) of contractor(s) who performed the services. Describe the activities performed by each named contractor, actual hours spent on the mandate, inclusive dates when services were performed and itemize all costs for services performed. Attach consultant invoices with the claim.

Source documents required to be maintained by the claimant may include, but are not limited to, contracts, invoices, and other documents evidencing the validity of the expenditures.

4. Travel

Travel expenses for mileage, per diem, lodging and other employee entitlement are reimbursable in accordance with the rules of the local jurisdiction. Give the name(s) of the traveler(s), purpose of the travel, inclusive travel dates, destination points and costs.

Source documents required to be maintained by the claimant may include, but are not limited to, receipts, employee's travel expense claims, and other documents evidencing the validity of the expenditures.

5. Jury Expenses

Indicate for each court case, the court case number, number of juror days required to try the case, daily juror rate, number of days spent trying the case.

Source documents evidencing the validity of the expenditures must be maintained by the claimants.

6. Care and Custody

Indicate names for each defendant, the court case numbers, number of days housed in the county's jail facility, and the county's daily jail rate.

Source documents evidencing the validity of the expenditures must be maintained by the claimants.

B. Form 1, Claim Summary

This form is used to summarize direct costs by claim component and compute allowable indirect costs for the mandate. Claim statistics shall identify the amount of work performed during the claim period for which costs are claimed. Claimant must show the number of MDSO cases heard in court for extended commitment pursuant to Section 6316.2 W & I Code. Direct costs on this form are carried forward from form 2.

Indirect costs may be computed as 10% of direct labor, excluding fringe benefits. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim. If more than one department is involved in the mandated program, each department must have their own ICRP.

C. Form FAM-27, Claim for Payment

This form contains a certification that must be signed by an authorized representative of the county. All applicable information from form MDSO-1 must be carried forward to this form in order for the State Controller's Office to process the claim for payment.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
MENTALLY DISORDERED SEX OFFENDERS: EXTENDED COMMITMENTS

For State Controller Use Only

(19) Program Number 00039

(20) Date Filed ____/____/____

(21) LRS Input ____/____/____

Program 039

LABEL HERE

(01) Claimant Identification Number

(02) Claimant Name

County of Location

Street Address or P.O. Box Suite

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) **20___/20___**	(12) **20___/20___**
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Prior Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22) MDSO-1, (03)	
(23) MDSO-1, (04)(e)	
(24) MDSO-1, (05)	
(25) MDSO-1, (06)	
(26) MDSO-1, (08)	
(27) MDSO-1, (09)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	

(37) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code §17561, I certify that I am the officer authorized by the local agency to file mandated cost claims with the State of California for this program, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1098, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein, and such costs are for a new program or increased level of services of an existing program. All offsetting savings and reimbursements set forth in the Parameters and Guidelines are identified, and all costs claimed are supported by source documentation currently maintained by the claimant.

The amounts for this Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs set forth on the attached statements. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature of Authorized Officer Date

Type or Print Name Title

(38) Name of Contact Person for Claim

Telephone Number **( ) - Ext.**

E-Mail Address

Program 039	MENTALLY DISORDERED SEX OFFENDERS: EXTENDED COMMITMENTS Certification Claim Form Instructions	FORM FAM-27

(01) Enter the payee number assigned by the State Controller's Office.

(02) Enter your Official Name, County of Location, Street or P. O. Box address, City, State, and Zip Code.

(03) If filing an estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing a combined estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended estimated claim, enter an "X" in the box on line (05) Amended.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of the estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form MDSO-1 and enter the amount from line (10). If more than one form is completed due to multiple department involvement in this mandate, add line (10) of each form.

(08) Enter the same amount as shown on line (07).

(09) If filing a reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing a combined reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended reimbursement claim, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of the reimbursement claim from form MDSO-1, line (10). The total claimed amount must exceed $1,000.

(14) Reimbursement claims must be filed by January 15 of the following fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter zero if the claim was timely filed, otherwise, enter the product of multiplying line (13) by the factor 0.10 (10% penalty), or $1,000, whichever is less.

(15) If filing a reimbursement claim and a claim was previously filed for the same fiscal year, enter the amount received for the claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16), Net Claimed Amount, is positive, enter that amount on line (17), Due from State.

(18) If line (16), Net Claimed Amount, is negative, enter that amount in line (18), Due to State.

(19) to (21) Leave blank.

(22) to (36) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (36) for the reimbursement claim, e.g., MDSO-1, (03), means the information is located on form MDSO-1, line (3). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, i.e., no cents. Indirect costs percentage should be shown as a whole number and without the percent symbol, i.e., 35.19% should be shown as 35. **Completion of this data block will expedite the payment process**.

(37) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer, and must include the person's name and title, typed or printed. **Claims cannot be paid unless accompanied by an original signed certification**. **(To expedite the payment process, please sign the form FAM-27 with blue ink, and attach a copy of the form FAM-27 to the top of the claim package.)**

(38) Enter the name, telephone number, and e-mail address of the person to contact if additional information is required.

SUBMIT A SIGNED ORIGINAL, AND A COPY OF FORM FAM-27, WITH ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

Program 039	MANDATED COSTS MENTALLY DISORDERED SEX OFFENDERS: EXTENDED COMMITMENTS CLAIM SUMMARY	FORM MDSO-1

(01) Claimant	(02) Type of Claim	Fiscal Year
	Reimbursement ☐	
	Estimated ☐	20___/20___

Claim Statistics

(03) Number of cases heard in court for extended commitment to Welfare and Institutions Code Section 6316.2	

Direct Costs	**Object Accounts**				
(04) Reimbursable Component	(a) Salaries	(b) Benefits	(c) Services and Supplies	(d) Other Charges	(e) Total
Extending Commitment of Mentally Disordered Sex Offender					

Indirect Costs

(05) Indirect Cost Rate	[From ICRP]	%
(06) Total Indirect Costs	[Line (05) x line (04)(a)] or [line (05) x {line (04)(a) + line (04)(b)}]	
(07) Total Direct and Indirect Costs	[Line (04)(e) + line (06)]	

Cost Reduction

(08) Less: Offsetting Savings, if applicable	
(09) Less: Other Reimbursements, if applicable	
(10) Total Claimed Amount [Line (07) - {line (08) + line (09)}]	

Program 039	MENTALLY DISORDERED SEX OFFENDERS: EXTENDED COMMITMENTS CLAIM SUMMARY Instructions	FORM MDSO-1

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

Form MDSO-1 must be filed for a reimbursement claim. Do not complete form MDSO-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form MDSO-1 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) Enter the number of cases heard in court for extended commitment pursuant to Welfare and Institutions Code Section 6316.2.

(04) Reimbursable Components. For each reimbursable component, enter the total from form MDSO-2, line (05), columns (d), (e), (f), and (g) to form MDSO-1, block (04), columns (a), (b), (c), and (d) in the appropriate row. Total each row.

(05) Indirect Cost Rate. Indirect costs may be computed as 10% of direct labor costs, excluding fringe benefits, without preparing an ICRP. If an indirect cost rate of greater than 10% is used, include the Indirect Cost Rate Proposal (ICRP) with the claim.

(06) Total Indirect Costs. If the 10% flat rate is used for indirect costs, multiply Total Salaries, line (04)(a), by the Indirect Cost Rate, line (05). If an ICRP is submitted and both salaries and benefits were used in the distribution base for the computation of the indirect cost rate, then multiply the sum of Total Salaries, line (04)(a), and Total Benefits, line (04)(b), by the Indirect Cost Rate, line (05). If more than one department is reporting costs, each must have its own ICRP for the program.

(07) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (04)(d), and Total Indirect Costs, line (06).

(08) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(09) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(10) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (08), and Other Reimbursements, line (09), from Total Direct and Indirect Costs, line (07). Enter the remainder on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

Program 039	MANDATED COSTS MENTALLY DISORDERED SEX OFFENDERS: EXTENDED COMMITMENTS COMPONENT/ACTIVITY COST DETAIL	FORM MDSO-2

(01) Claimant

(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Component: Extending Commitment of Mentally Disordered Sex Offenders

(04) Description of Expenses: Complete columns (a) through (g). **Object Accounts**

(a) Employee Names, Job Classifications, Functions Performed, and Description of Services and Supplies	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries	(e) Benefits	(f) Services and Supplies	(g) Other Charges
(05) Total ☐ Subtotal ☐ Page:____of____						

Program 039	MENTALLY DISORDERED SEX OFFENDERS: EXTENDED COMMITMENTS COMPONENT/ACTIVITY COST DETAIL Instructions	FORM MDSO-2

(01) Enter the name of the claimant.

(02) Enter the fiscal year for which costs were incurred.

(03) Reimbursable Component: Extending Commitment for Mentally Disordered Sex Offenders. This line identifies costs that may be claimed on form MDSO-2.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in block (03), enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, travel expenses, care and custody of the patient, juror fees, contract services, etc. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than three years after the date the claim was filed or last amended, whichever is later. If no funds were appropriated and no payment was made at the time the claim was filed, the time for the Controller to initiate an audit shall be from the date of initial payment of the claim. Such documents shall be made available to the State Controller's Office on request.

Object/ Sub object Accounts	Columns						Submit these supporting documents with the claim
	(a)	(b)	(c)	(d)	(e)	(f)	
Salaries	Employee Name Title Activities	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked			
Benefits		Benefit Rate		Salaries	Benefits = Benefit Rate x Salaries		
Services and Supplies Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Used	
Contract Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service			Cost = Hourly Rate x Hours Worked Or Total Cost.	Invoice
Travel Expenses	Purpose of Trip Name and Title Departure and Return Date	Per Diem Rate Mileage Rate Travel Cost	Days Miles Travel Mode			Total Travel Cost = Rate x Days or Miles	
Jury Expenses	Number of Jurors	Daily Juror Rate	Inclusive Trial Dates			Total Cost Claimed	
Other Charges Support and Care of Persons	Number of Defendants	Cost per Day	Number of Days			Cost = Cost per Day x Number of Days	

(05) Total line (04), columns (d), (e), (f), and (g) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component/ activity costs, number each page. Enter the totals from line (05), columns (d), (e), (f), and (g) to form MDSO-1, block (04), columns (a), (b), (c), and (d) in the appropriate row.